Rational Management of Optician's Letters

Mr Nick Jacobs, Consultant Ophthalmologist and clinical lead for The Practice Ophthalmology Service, outlines the rational management of optician's letters.

The Practice Ophthalmology Service is an Intermediate care provider of ophthalmology and manages around 20,000 new referrals per year, running approximately 90 community based clinics a week.

Referrers are not always sure what information to send with the referral, in my experience the following may be useful.

- There is no need to summarise or try to interpret the optician's findings please however don't forget to include a copy of the optician's report
- Medical history is especially useful. You may find it easier to include a print out which is a little less personal but still contains all the relevant information
- Cataract referrals should always include an optician's referral

This lady's eye pressure is raised in her right eye. I enclose a recent GOS18 from her optician

Active Problems

8.12.2005	Nocturia	
8.12.2005	Raised intra-ocular pressure	
24.4.2004	Therapeutic epidural injection	
5.10.2000	Asthma	Follow-up resp. assessment , Asthma , Dry cough , Asthma prophylaxis used , PEF 300 l/minute , PrPEF 431 l/min ,

Significant Past

18.8.2005 Spinal stenosis

Figure 1: Illustration of referral with regards to GOS18 which includes helpful past medical history, past ocular history and current medication

Dear Colleague

I would appreciate it if you could see this lady, who had intracapsular extraction of the cataract on the right hand side in 2003, who appears to have posterior capsular thickening.

Yours sincerely

Figure 2: Illustration of referral with incorrect description of type of cataract surgery

Typical conditions:
1. Macular Degeneration

Age Related Macular Degeneration (ARMD)

Just a few years ago, ARMD was essentially an untreatable condition although focal laser treatment was sometimes applied in a bid to ameliorate early wet macular problems. Recently, things have changed dramatically, first with photodynamic therapy (PDT), but particularly more recently with anti VEGF intraocular injections. This treatment is able to halt, control, and even reverse, wet macular degeneration. For this reason, it has become important to differentiate between dry and wet macular change.

Dry macular change can take the form of discreet or confluent cream coloured drusen or little bumps, pigment alteration giving a salt and pepper appearance or straightforward thinning and atrophy. These changes can cause gradual reduction and some distortion of central vision.

Wet macular change is characterised by a history of sudden visual change particularly central distortion with sub retinal fluid/haemorrhage on the retina.

Condition	**Example of Optician's observations**	**Referral Management**
Dry Macular	Distortion of the Amsler Chart with pigment or drusen appearance	Routine referral. The patient will often be discharged and offered advice about sudden changes in vision, which could signify a wet change
Wet Macular	Definite visual loss and a recent history of change	Urgent referral to a Macular Assessment Clinic within 1 – 2 weeks is required. This applies whether the optician has noticed any wet signs on the macula or not

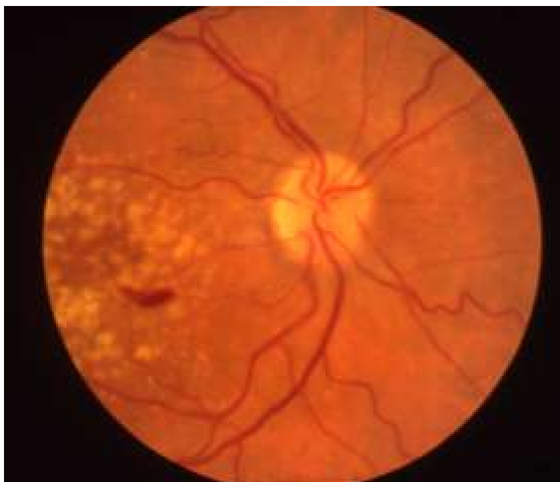


Figure 3: Illustration showing dry macular drusen with a recent wet macular haemorrhage

PRESCRIPTION DETAILS FROM CURRENT SIGHT TEST DATE:

Previous corrected VA

Date

Date of Birth

NHS NUMBER (If Known)

Specify Cycloplegic if used

	Unaided V	Sph	Cyl	Axis	Prism	Base	VA	Add	Near VA
RE	6/7.5	+1.00DS					6/5		
LE	6/9	+.75DS					6/7.5		

PLEASE COMPLETE BELOW AS APPROPRIATE

Disc Appearances: RE ... c/d 0.2 ... LE ... c/d 0.2

Intra-Ocular Pressures: RE ... mmHg LE ... mmHg Pneumo/Applanation Tonometer

Visual Fields: RE ... LE ... (Enclose Copy if available)

POINTS REQUIRING ATTENTION – FOR INFORMATION (AND POSSIBLE REFERRAL):

pt attended c/o reduced (L) acuity
opthalmoscopy revealed (L) macular abnormality
pigment possible drusen (R) normal
Amsler (L) distortion
please refer for further investigation

I agree / do not agree that any Ophthalmologist to whom I am referred for medical consultation and / or treatment may make information relevant to my eye condition and its treatment available to my Optometrist / Ophthalmic Medical Practitioner.

Signed ... Date ...

Name and Address of Optometrist/OMP

Signed (Optometrist/OMP)

Figure 4: Illustration of optician's referral letter for dry macular change

2. Retinal abnormality

Opticians usually carry out a very thorough examination of the patient's retina particularly the periphery. This leads to the discovery of all sorts of mild abnormalities.

An important finding under retinal abnormalities is retinal pigmented lesions. These range from an insignificant pigment spot to a dark, relatively large area, which is flat and sometimes surrounded by a paler area known as pigment epithelial hypertrophy. These are usually innocent; however a choroidal naevus, which may be raised, has the potential to become malignant and it is therefore recommended that all such conditions are referred.

It is necessary to obtain a reasonable photograph of the lesion via the optician or in the hospital and arrange for the patient to be reviewed on a regular basis, usually annually, with this photograph to hand. It does not matter whether this is done in a hospital setting or by the optician as long as change can be recognised.

Condition	Example of Optician's observations	Referral Management
Pigmented Lesion	Nevus appears flat with drusen.	It is very difficult for the general practitioner to determine whether these are worthy of onward referral and, thus, most of these do get referred.

PRESCRIPTION DETAILS FROM CURRENT SIGHT TEST DATE: | Previous corrected VA | Date of Birth NHS NUMBER (If Known) 10/12/7

	Uncorrected V	Sph	Cyl	Axis	Prism	Base	VA	Add	Near VA	Date
RE							6/5			
LE							6/5			

Specify Cycloplegic if used

PLEASE COMPLETE BELOW AS APPROPRIATE

Disc Appearances: RE .... LE ....

Intra-Ocular Pressures: RE 23, 19, 20 .... mmHg LE 22, 23, 22 .... mmHg Pneumo/Applanation Tor

Visual Fields: RE .... LE .... (Enclose Copy if av

POINTS REQUIRING ATTENTION – FOR INFORMATION (AND POSSIBLE REFERRAL):

On Retinal exam pt has a Naevus (Dark Brown Pigmented) ~ 2/3 Disc Diameter in size, to the fundus of LE — appears flat with Drusen (exudate?) on Naevus. Would value a future Ophth. / medical opinion

I agree / do not agree that any Ophthalmologist to whom I am referred for medical consultation and / or treatment may make information relevant to my eye condition and its treatment available to my Optometrist / Ophthalmic Medical Practitioner.

Name and Address of Optometrist/O

Signed .... Date .... Signed (Optometrist/OMP) S. H

Figure 5: Illustration of optician's referral for retinal abnormality including a helpful diagram

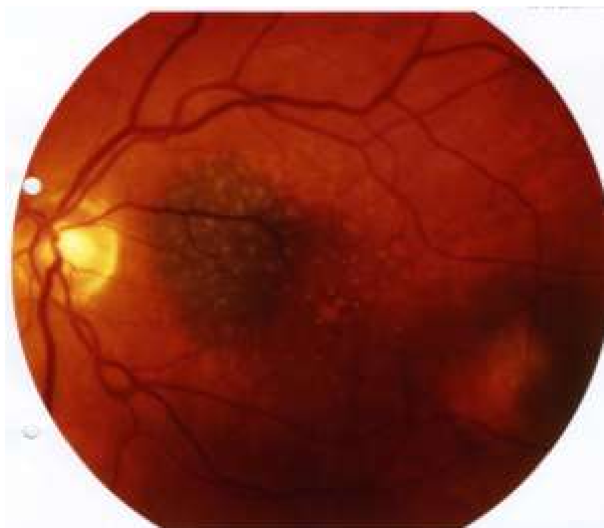


Figure 6: An example of a patient showing a choroidal naevus with some overlying drusen which requires monitoring

3. Pupil abnormalities

Patients are often referred by the optician with pupil abnormalities. The most common abnormality is unequal pupil size or anisocoria. Anisocoria is only significant if there is a ptosis on the side of the small pupil or the pupils are not reactive to light. In the presence of normal lid position and reactive pupils, anisocoria is never significant. Thus, if the only query made by the optician is anisocoria and active pupils, it is reasonable not to refer this patient on. In the presence of a ptosis, a Horner's Syndrome is a possibility although these are rare cases.

In an unreactive pupil a diagnosis of ADIE pupil is likely. This is a relatively common condition. A natural history of ADIE pupil is to start large and unreactive, eventually ending up very small and still unreactive. It is common for the second eye to be affected at a later stage.

4. Flashers & Floaters

Ocular migraine is the experience of visual symptoms caused by underlying migrainous pathology. The episodes are usually typical and not necessarily accompanied by a headache. The history is often an individual having true migraines in earlier life and developing ocular migraine without headaches in midlife. These episodes will normally last 15 – 30 minutes and consists of zigzag and/or coloured lights, grey and white patches. They are generally incapacitating and make activities such as driving dangerous.

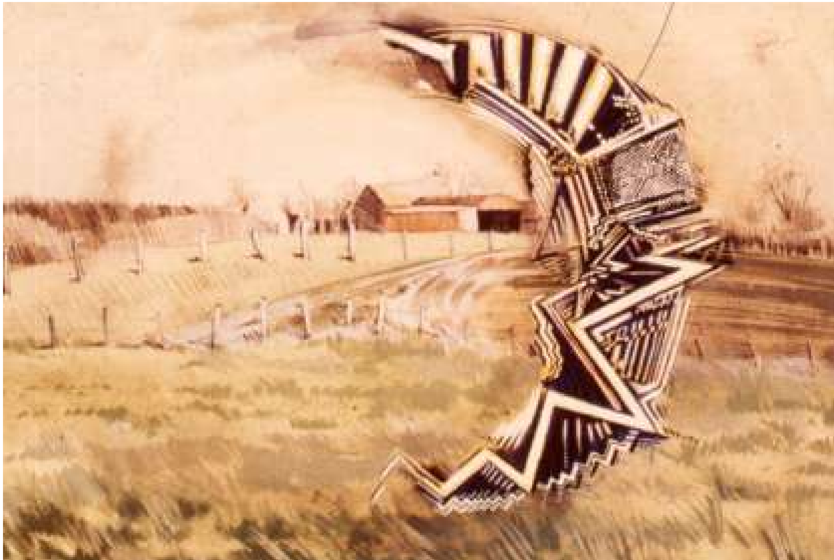
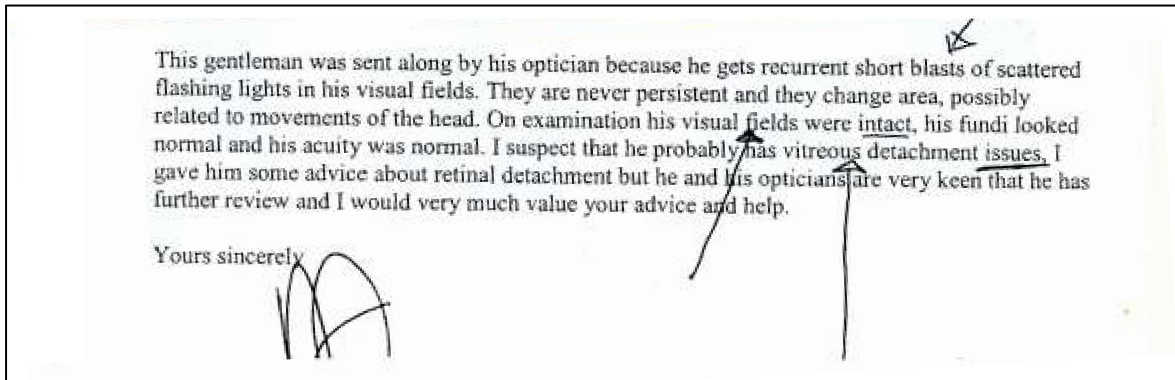


Figure 7: An impression of a typical migraine episode

Posterior vitreous detachment is an extremely common condition and usually experienced by patients in late middle age or earlier in myopia. The patient will typically complain of a floater affecting one eye and brief flashes of light in the far periphery of that eye usually occurring in the evening or darkened conditions. We would dilate the pupil and ensure that apart from the vitreous detachment, the retina shows no evidence of damage. In 98% of cases, this will be the case and the patient will be advised that if there is any change in symptoms, such as persistent flashing lights during the daytime or the appearance of a cloud of spots blurring vision, that this could indicate damage to the retina and a further opinion should be sought soon.

Condition	**Example of Optician's observations**	**Referral Management**
Ocular Migraine	Scattered flashing lights in his visual fields	The history is absolutely typical and cannot be anything else. Such patients do not need to see an ophthalmologist but need a decision from the general practitioner as to whether to give the patient treatment for migraine prophylaxis if they are frequent enough to be a problem.
Posterior Vitreous Detachment	Floaters related to movements of the head	We normally like to see these patients and the degree of urgency would be soon, in the region of 2 weeks.


This gentleman was sent along by his optician because he gets recurrent short blasts of scattered flashing lights in his visual fields. They are never persistent and they change area, possibly related to movements of the head. On examination his visual fields were intact, his fundi looked normal and his acuity was normal. I suspect that he probably has vitreous detachment issues, I gave him some advice about retinal detachment but he and his opticians are very keen that he has further review and I would very much value your advice and help.

Yours sincerely

Figure 8: A GP referral letter suggesting vitreous detachment 'issues'

5. Glaucoma – intraocular pressure, cupped discs and visual field abnormalities

Intraocular pressure (IOP)

An increase in optician referral due to raised intraocular pressure may well have been noticed recently. This is all due to the NICE Guidelines on Glaucoma for 2 main reasons. The first is that the guidelines recommend referral of a pressure of 22 or more combined with the fact that the opticians are obliged to refer these patients by their insurers. The second reason is that most opticians do non contact tonometry which tends to over- estimate the pressure quite regularly. The way to improve this situation is at least to ensure that opticians are rechecking pressure before referring with a Goldman Applanation Tonometer. This is now being addressed by various schemes around the country.

If the pressure is raised but there is no concern about the optic disc or the visual field then the diagnosis being queried is ocular hypertension. To determine whether this is present the corneal thickness or pachymetry must be measured. There is a guideline to show the acceptable combination of pressure and corneal thickness.

Cupped disc

Cupped discs are often recognised by opticians either unilaterally or bilaterally. Asymmetry in disc cupping is significant.

Condition	Example of Optician's observations	Referral Management
Cupped Disc	Disc asymmetry. Left disc looks suspicious	Routine referral. If the discs are suspicious, even if the intraocular pressure and visual fields appear to be normal, these patients need to be assessed.

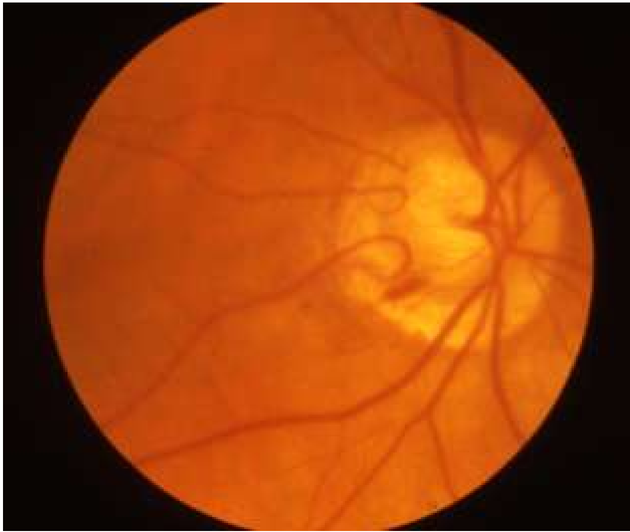


Figure 9: Illustration of a cupped optic disc and a disc margin haemorrhage typical of normal tension glaucoma

PTION DETAILS FROM CURRENT SIGHT TEST DATE 28.11.05

V	Sph	Cyl	Axis	Prism	Base	VA	Add	Near VA	Date 27.10.04
/18	+1.25	-0.75	85			6/7.5	+2.25	NS	6/7.5
/18	+1.25	-0.25	70			6/9	+2.25	NS	6/9

NHS NUMBER: 1933

COMPLETE BELOW AS APPROPRIATE

Appearances RE C D 0.2 LE C D 0.6 pale, narrowing rim

Ocular Pressures RE 18 mmHg LE 19 mmHg Pneumo/Applanation Tonometer @ 11am

Fields RE full to 30° (32 d8) LE full to 30° (36 d8) (Enclose Copy if available)

REQUIRING ATTENTION FOR INFORMATION (AND POSSIBLE REFERRAL)

asymmetry. L disc looks so suspicious.
would you refer to ophthalmology to confirm or eliminate the possibility of glaucoma

Figure 10: Illustration showing optician referral of asymmetric cupping with normal pressures and fields

Visual field abnormality

The hospital standard of visual field test is the Humphrey machine on a full threshold central programme. In the optician community, there are a large range of different types of visual field machines and types of visual field assessment programmes that can be used. Often patients are referred with one or two spots missing or an edge defect, which is often an artefact. An experienced clinician will know from assessing the optic disc that some field tests do not require repeating.

Some visual fields are definitely abnormal in appearance and compatible with a diagnosis of glaucoma.

More latterly, laser retinal scanning technology is used to assess and monitor optic disc and retinal nerve fibre layer thickness in glaucoma patients.

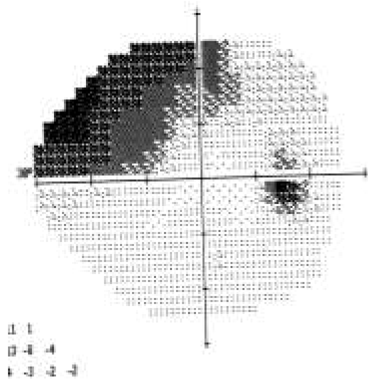


Figure 11: Illustration of Humphrey Visual Field test with definite superior glaucoma field loss

Condition	Example of Optician's observations	Referral Management
Neurological Field Loss	Visual field abnormality. Fields enclosed.	Some patients may be referred with typical neurological field loss, such as homonymous hemianopia. They do not require referral to an ophthalmologist. Management by the GP depends on whether there is a known history of stroke or other neurological problem and whether referral to a neurologist is appropriate.

Visual fields and driving

There is a certain amount of confusion around this topic. The DVLA must be informed by law if both eyes have a true defect of the field of vision. Also, if there is a visual field defect in one eye or both eyes, the car insurer must be informed as the insurance may become invalid if the information is not passed on.

6. Cataract

It is most important that patients being referred for cataract have an optician assessment included. Referral of a cataract patient without such an assessment should be considered as an incomplete referral.

A nuclear cataract, which is a dense brown cataract where the centre of the lens hardens gradually, will cause a change in refraction. The eye will become gradually more myopic.

Following cataract surgery some patients will develop thickening of the posterior capsule, which will then be referred on by the optician for consideration of a YAG laser capsulotomy.

the practice+

PRESCRIPTION DETAILS FROM CURRENT SIGHT TEST DATE: 2.3.06

Previous corrected V.A.

Date

Date of Birth 11-4.30
NHS NUMBER (If Known):

Specify Cycloplegic if Used.

	Uncorrected V	Sph	Cyl	Axis	Prism	Base	VA	Add	Near VA
RE	6/48	+300	DS				6/12	+	
LE	6/48	+300	+125	160		N1AH	6/15-	250	

PLEASE COMPLETE BELOW AS APPROPRIATE

Disc Appearances: RE ....0.3.... LE ....0.3....

Intra-Ocular Pressures: RE ....17.... mmHg LE ....24, 26, 17 .... 1228 mmHg Pneumo/Applanation Tonometer

Visual Fields: RE .... LE ....(Enclose Copy if available)

POINTS REQUIRING ATTENTION - FOR INFORMATION (AND POSSIBLE REFERRAL):
Px has advanced cataract RE causing blurred vision.
please refer to an ophthalmologist.
with thanks.

NB// LE amblyopic

I agree / do not agree that any Ophthalmologist to whom I am referred for medical consultation and / or treatment may make information relevant to my eye condition and its treatment available to my Optometrist / Ophthalmic Medical Practitioner.

Signed .... Date ....

Figure 12: A typical optician's referral including useful information about the degree of patient's hypermetropia and anisometropia of difference in refraction of the two eyes, and also gives information about the history of amblyopia in one eye and possibly raised pressure

Vision	Sph	Cyl	Axis	Prism	Base	VA	Add	Near VA	Previous VA	2/04
	-1.00	+1.00	120			6/7.5	+2.50	N5		
	-2.50	+1.25	55			6/12-	+2.50	N8	6/7.5	N5

c Appearance: RE LE

a-Ocular Pressures: RE 16 mm Hg LE 19 mm Hg Pulsair

ual Fields: RE LE

INTS REQUIRING ATTENTION – FOR INFORMATION (AND POSSIBLE REFFERAL):

Loss of VA in the L eye.
Both eyes had cataract surgery in 2003.

The L eye has developed capsular opacities which may be amenable to laser treatment.

Referral for Ophthalmological assessment is advisable.

Figure 13: Illustration of optician's referral for thickened posterior capsule

Condition	Example of Optician's observations	Referral Management
Cataract	Advanced cataract Right Eye causing blurred vision. Left Eye amblyopic	Routine referral. Please include opticians assessment.

Mr Jacobs at The Practice Ophthalmology Service can be contacted at info@thepracticeplc.com. For further information on The Practice visit www.thepracticeplc.com